UNITED STATES MARINE CORPS
III MARINE EXPEDITIONARY FORCE, FMF
UNIT 35601
FPO AP 96606-5601

ForO 6000.1
16
22 APR 1996

FORCE ORDER 6000.1

From: Commanding General
To: Distribution List

Subj: MEDICAL QUALITY ASSESSMENT/QUALITY IMPROVEMENT (QA/QI) PROGRAM

Ref: (a) OPNAVINST 6320.7
(b) BUMEDINST 6010.13
(c) BUMEDINST 6320.66B
(d) MARFORPAC P6320.3A

Encl: (1) Sample Appointment Letter for QA/QI Committee Member
(2) Sample Appointment Letter for III MEF QA/QI Coordinator
(3) Sample Appointment Letter for PEER Review
(4) Sample Format for QA/QI Minutes
(5) Clinical Indicators/Aspects of Care
(6) Volume Indicator Tracking Sheet
(7) Outpatient Medical Record Review
(8) Issue Referral Report
(9) Patient Satisfaction Survey
(10) Clinical Performance Profile

1. Purpose. To establish policy, publish procedures, and assign responsibility for the Medical Quality Assessment and Quality Improvement (QA/QI) process within III Marine Expeditionary Force (III MEF).

2. Background. The Chief of Naval Operations and Commandant of the Marine Corps are committed to continuously improving the quality of medical and dental care provided to Department of the Navy beneficiaries. A Quality Assurance program was established in 1984 to standardize QA activities within Naval Medical Departments.

3. Goals. The goal of III MEF is to ensure that all health care provided is of high quality and that our QA/QI Program is an ongoing one, with planned procedures to objectively assess the quality of care, identify any current problems, and at the same time seek opportunities for improvement.

4. III Marine Expeditionary Force QA/QI Plan (TEN STEP PROCESS)

a. Assign Responsibility (STEP 1)

(1) Bureau Of Medicine And Surgery (BUMED). BUMED is the governing body for all medical units under III MEF. BUMED sets policy, provides guidance, conducts educational programs and serves as a resource for the QA/QI program. The Navy Surgeon General is the privileging authority.

(2) Commanding General. The Commanding General, III MEF is the governing body's representative, the privileging authority for III Marine Expeditionary Force and approves the command QA/QI plan. He is responsible for establishing, maintaining and supporting an ongoing QA/QI program, and resolving QA/QI related problems that cannot be addressed and resolved at lower levels.

(3) Chief Of Staff. Reviews the minutes of all QA/QI meetings and submits recommendations to the Commanding General.

(4) Force Surgeon

(a) Principal advisor to the Commanding General for all medically related QA/QI issues.

(b) Serves as the Chairman of the III MEF QA/QI Committee.

(c) Has the responsibility for oversight and guidance of the QA/QI Program.

(d) Reviews and forwards the minutes of the QA/QI meetings to the Commanding General via the Chief of Staff, with recommendations for final action on unresolved problems or issues.

(5) III MEF QA/QI Coordinator

(a) Appointed by the Force Surgeon and is responsible for collection and coordination of QA/QI data.

(b) Serves as a member of the III MEF QA/QI committee.

(c) Assists battalion/squadrons and regimental/group coordinators with their programs and resolving problems.

(d) Maintains on file all reports and documentation presented to the force QA/QI committee.

(e) Initiates agenda items and submits minutes of the III MEF QA/QI meetings through the proper chain.

(f) Assists the force QA/QI committee chairman in the annual reappraisal of the force QA/QI program.

(6) III MEF QA/QI Committee

(a) Chairman. The Force Surgeon is the Chairman for the Force QA/QI Program.

(b) Membership. Membership shall be appointed by the Force Surgeon. Committee consists of but is not limited to the following personnel:

1 Chairman.

2 Battalion/squadron surgeons or representative.

3 Environmental Health Officer.

4 Force QA/QI Coordinator.

5 Aid Station Chiefs.

(c) Responsibilities

1 Meets quarterly to discuss any problems and issues that relate to delivery of care within III MEF.

2 Serves in an oversight and advisory role, performs data analysis, and trending to identify opportunities for improvement.

3 Reports to the Commanding General, III MEF.

4 Ensures information from QA/QI program flows back to aid stations.

5 Identifies, assesses, directs and monitors any corrective actions taken involving standards of care, record keeping or any other aspects of medical care.

6 Reappraises the effectiveness of the QA/QI program bi-annually.

(7) Regimental/Battalion/Group/Squadron QA/QI Committee

(a) Is responsible for coordination and integration of the QA/QI program within the unit/organization.

(b) Meets monthly to discuss problems and issues identified or related to quality medical care.

(c) Submits minutes to respective Commanding Officer via the Force Surgeon.

(d) Appoints regimental and battalion QA/QI coordinators.

(8) Battalion QA/QI Coordinator

(a) Is knowledgeable of the QA/QI process and current requirements.

(b) Orients new staff to the QA/QI program.

(c) Assists the battalion committee in coordinating, planning, and conducting monthly meetings.

(d) Prepares monthly QA/QI minutes to be submitted to the respective commanding officer via the Force Surgeon.

b. Delineate The Scope Of Care (STEP TWO)

(1) Scope Of Care

(a) General Health Care.

(b) Immunizations.

(c) Minor Surgery.

(d) Musculoskeletal Injuries.

(e) Pharmacy.

(f) Physical Examinations.

(g) Preventive Medicine.

(h) Sickcall.

(i) Health Promotion and Education.

(j) Medical Coverage for Operational and Recreational Activities.

c. Identify The Important Aspects Of Care (STEP 3)

(1) III MEF has identified the following important aspects of care to be assessed within the MEF:

(a) Important Aspects Of Care

1 Access to Care.

2 Emergency Care.

3 Infection Control.

4 Medical Records Review.

5 Use of Medications.

6 Customer Satisfaction.

7 Patient Safety.

8 Education of Patients.

(b) In addition to the command-wide important aspects of care, each unit examines its scope and identifies and prioritizes important aspects of care and service based on high risk, high volume, problem prone, high cost and/or key functions.

d. Identify Indicators (STEP 4)

(1) Clinical indicators are developed to routinely monitor important aspects of care. A clinical indicator is a quantitative measure that can be used as a guide to monitor and evaluate the quality of patient care and support service activities. Indicators are of two general types: SENTINEL and RATE-BASED. A "sentinel" event is a serious or undesirable, low frequency and often avoidable process or outcome. A "rate-based" indicator usually measures an event for which a certain rate is acceptable. As data is collected over a number of cases, there can be a "threshold" established so as to trigger a more in-depth review. The indicator may be an "outcome" or "process" indicator.

(2) EACH AID STATION WILL MONITOR A MINIMUM OF TWO CLINICAL INDICATORS BASED ON ONE OR MORE IMPORTANT ASPECTS OF CARE. THIS SHOULD BE ONGOING AT ALL TIMES. Initially, results will be documented in the aid station's monthly QA/QI minutes on a monthly basis and, thereafter, at least on a quarterly basis, utilizing the format in enclosure 4. Indicators will be determined and monitored by the Force Surgeon.

e. Establish Thresholds For Evaluation (STEP 5)

(1) When data is collected there can be a "threshold" established to trigger more in-depth review. A threshold is a "yardstick" or "gauge" against which the quality and appropriateness of an aspect of care (as defined by an indicator) can be measured. Thresholds can be identified or developed through review of literature, national standards, statistical limits, patients needs, or a review of III Marine Expeditionary Force policies, procedures and experience. Thresholds will be reevaluated for possible re-establishment at least once a year.

(2) Thresholds are not absolute standards of care. They are tools for identifying practices or processes that should be subjected to closer scrutiny by the clinical staff. Other mechanisms that may prompt intensive evaluation include:

(a) Desire to improve overall performance.

(b) Benchmarking (comparing one's performance with others).

(c) Staff observations and recommendations.

(d) Evaluation of customer needs, satisfaction or dissatisfaction.

(e) Patterns and trends in indicator data.

f. Collect and Organize Data (STEP 6)

(1) Each aid station will have a designated QA/QI coordinator responsible for coordinating monthly data collection and reporting in minute format. Sources of data include QA/QI database, clinic logs, patient medical records survey, radiology and laboratory reports, medication prescriptions, minutes, other reports or direct observation of staff or patients.

(2) Each QA/QI coordinator will plan data collection methods for each indicator selected. The following questions will be recorded prior to collection of data:

(a) Who will collect and organize data?

(b) Will collection be prospective or retrospective?

(c) What is the frequency of review?

(3) Data collection will include medical record and minor surgery procedure review data based upon preestablished criteria. All minor surgical procedures will be reviewed. In addition, a minimum of five medical records per week, per provider, will be reviewed. A minimum of 20 percent of health records must be reviewed for provider with preceptor. One hundred percent of all corpsman records will be reviewed by medical officer or independent duty corpsman.

g. Evaluate Care and Service Against Thresholds (STEP 7)

(1) Aid stations will hold monthly meetings to discuss the results of their monitoring and evaluation activities. They will decide what needs to be studied in more detail and they will set priorities for further review with guidance from the Force Surgeon.

(2) Two major ways care/services are evaluated

(a) Indicator Assessment

1 When the cumulative data reaches or exceeds the predetermined threshold, the staff will evaluate the data provided to determine whether an opportunity for improvement or a problem exists.

2 When the cumulative review data does not exceed the threshold over a period of time, reevaluate the predetermined threshold to determine if it is appropriate for the aid station. If it is appropriate, then consider changing to a new clinical indicator with a special follow-up assessment of the old clinical indicator in 3 to 6 months to insure continued satisfactory performance. Another approach would be to make the existing threshold more stringent. For example: If a one hour patient waiting time threshold was consistently being met, then consider changing the threshold to 30 or 45 minutes.

(b) Peer Review. Peer review is a fair evaluation of health care practices, by those who have training and experience similar to, but not necessarily the same specialty, of the individual providing care. The purpose is to improve practices, reduce morbidity and mortality, and to provide the basis for appointments, reappointments, and privileging of staff. Within III Marine Expeditionary Force, clinical care reviews evaluates the outcome of individual care.

h. Take Actions To Improve Care and Service (STEP 8)

(1) Aid stations will indicate action to achieve improvement in care or services once an opportunity for improvement has been

identified. Action items include:

(a) System Issues

1 Adjust communication channels.

2 Adjust staffing.

3 Change forms.

4 Establish and impovement monitoring.

(b) Knowledge Issues

1 Provide in service education.

2 Provide continuing medical education.

(c) Behavior issues

1 Provide formal and informal counseling.

2 Change assignment.

3 Disciplinary action.

(2) The item status report will be the tool used in the monthly QA/QI minutes to identify issues, track the progress of action taken to improve the process, and to document improvements made in care or services. An attendance matrix will be maintained to document attendance of pertinent personnel.

i. Assess Actions And Document Improvement (STEP 9)

(1) If actions taken are effective, continued assessment of these actions will take place in an attempt to maintain improvement. The results of continued monitoring and evaluations are carefully documented to provide a record of the efficacy of the process.

(2) Once success has been maximized and further efforts gain only minimal results, important aspects of care and indicators will be reevaluated. Important aspects of care or service will be reviewed regularly.

j. Communicate Relevant Information MEF-Wide (STEP 10)

(1) In an effort to improve care, minimize duplication of effort, and ensure that relevant findings are used in the periodic reappraisal of providers, information derived from monitoring and evaluation is shared among Aid Stations and through the chain of command. III MEF QA/QI Plan information is shared by the following methods:

(a) QA/QI reports/minutes.

(b) QA/QI biannual reviews.

(c) QA/QI training for QA/QI representative and committee chairman.

(d) Group and 1 to 1 QA/QI consultations.

(e) QA/QI memoranda.

(2) QA/QI Reports: A monthly QA/QI committee meeting, chaired by the Battalion Surgeon will be held during the first week of each month, at the respective aid stations.

(3) A Force QA/QI meeting, chaired by the Force Surgeon with regimental and battalion aid station QA/QI coordinators, Senior Medical Department Representatives and surgeons, will be held quarterly at the III Marine Expeditionary Force Headquarters.

(4) Each aid station QA/QI coordinator will be responsible for monthly minutes formulation guided by the committee chairman and submitted via the reporting chain of command. Enclosure (4) is a common format for content of QA/QI reports. All reports are to arrive at the III MEF Surgeon's Office no later than five working days following the meeting. Minutes will be routed as follows:

(a) Aid Station QA/QI Meeting

1 Battalion Aid Station QA/QI coordinator.

2 Force Surgeon.

3 Commanding Officer of respective Aid Station.

(b) III MEF QA/QI Meeting

1 III MEF QA/QI coordinator.

2 III MEF Surgeon.

3 III MEF Staff Judge Advocate.

4 III MEF Chief of Staff.

5 III MEF Commanding General.

5. CRAF Terminology/Elements

a. The CRAF format will be used to communicate our thought process as follows:

C - Comments/findings

R - Recommendations

A - Actions

F - Follow-up

b. Findings

(1) Although not part of the CRAF acronym, each presentation of the results of monitoring and evaluation should begin with a summary statement of the findings. Findings are the data about the aid stations performance. The following questions should be answered by the "Findings" section:

(a) What was monitored?

(b) What was the monitoring time period?

(c) What was the total volume of activity under review (e.g. number of patient, number of procedures, number of encounters, etc.)?

(d) What volume of activity was monitored (e.g., sample size)?

(e) What was the performance, based on the percentage of activity meeting the indicators compared to the total volume of activity monitored?

(f) Is there a significant variance between the aid station's performance and a predetermined desired level of performance?

(2) There may be reference to control charts, graphs, trend charts, or other tools for data display used by the committees to

review the findings. These tools should be attached to the minutes.

c. Conclusion. After the findings are presented, the conclusion represents the group's evaluation and analysis of the data. The conclusion is the group's diagnosis and gives an explanation or reason for the recommendation and action to follow. Key points to cover in the "conclusion" section are outlined with the following questions:

(1) Does the significant variance represent a pattern or trend in care or outcome, or a variance due to special cause?

(2) Is there opportunity for improvement?

(3) If there is an opportunity to improve, what is the root cause of the problem (e.g., systems, knowledge or skills, behavior, or root cause is unclear)?

(4) If there is an opportunity to improve, does the scope of the problem (e.g., level of impact) necessitate immediate action?

(5) If an opportunity to improve or a problem is not evident, is the monitoring tool appropriately constructed (e.g., aspect of care, indicators, sampling, and data collection techniques/frequency are valid)?

d. Recommendation. The recommendation represents a general description of what will be done to improve. The recommendation should be appropriate to the command's or committee's authority to act. The recommendation should be based on the priority of the opportunity, the assessment of the root cause of the problem, complexity of the processes involved and need for quick action as determined by the severity of the problem. The command or committee should have a goal for improving outcomes and/or efficiency. The following questions should be answered in the "Recommendation" section:

(1) If the conclusion is that there is an opportunity to improve, but it is not within the scope of the command's or committee's authority to take direct action, is referral to higher authority, committee or supporting MTF recommended?

(2) If the conclusion is that there is an opportunity to improve, and it is within the command's or committee's authority to take direct action, and the root cause is clear, the processes involved are not complex, and quick action is desirable, is action appropriate to the root cause recommended as follows?:

(a) Improve communications, additional staffing or technology, revise policies and procedures, improve or interdisciplinary coordination/integration.

(b) Knowledge or skill - provide classes, in services, seminars, reference resources, proctoring, and enhanced orientation.

(3) If the conclusion is that an opportunity to improve is not evident, but that the monitoring tool is not appropriately constructed to accurately measure performance and outcomes, are changes to the monitoring tool recommended?

(4) If the conclusion is that an opportunity to improve is not evident and that the monitoring tool is appropriately constructed, no changes should be recommended.

e. Action Plan

(1) The action plan is a specific description of what will be done, including assignment of responsibility and time frame for completion. The action plan may include the testing of a strategy for improvement on a limited basis prior to full implementation. The action plan should answer the following questions:

(a) What specifically will be done?

(b) What is expected to change, (e.g., what is the goal)?

(c) Who is responsible for implementing action?

(d) When is the action expected?

(2) The action plan should match the scope of the problem, (e.g., if only one individual is causing the problem, the action should target that individual versus the whole staff).

f. Follow-up. The follow-up represents the interval of time in which the effectiveness of the action taken is assessed. This assessment is accomplished either by initiating monitoring or continuing ongoing monitoring of the care and reporting back to the division or committee. The following questions should be answered in the "Follow-up" section.

(1) How will the effectiveness of the action taken be assessed, (e.g., either new or ongoing monitoring of care)?

(2) When will the new data be presented to the command or committee?

g. If the committee minutes were a medical record

(1) Findings would be the lab, x-ray, and electrodiagnostic results.

(2) Conclusion would be the working diagnosis.

(3) Recommendation would be the general treatment plan including social consultation.

(4) Actions would be the doctor's orders.

(5) Follow-up would be the plans for monitoring the patient's condition, including repeating lab, x-ray, and electrodiagnostic testing, and tracking the patient's progress all the way through to discharge.

6. Annual Assessments

a. Annual evaluation of the QA/QI plan/program: The Force Surgeon will be responsible for reviewing this plan/program annually in December.

b. Credentials/Cerification Review: Credentials/Cerification review of aid station providers is performed biannually by the Force Surgeon. Activities that provide information for this review include but are not limited to:

(1) Clinical activity file.

(2) Direct Observation.

(3) Medical Record Review.

(4) Occurrence Screens.

(5) Medical Staff Monitors.

(6) Risk Management Activities.

(7) Patient Complaint and Satisfaction Data.

7. Management Variance Report (MVR)

a. The following events will initiate a MVR

(1) Problems with equipment or supplies.

(2) Fire.

(3) Altercation/Abuse.

(4) Complaints.

(5) Patient refusal of treatment or leaving "against medical advise" (A.M.A.).

b. The MVR must answer the following questions

(1) What happened?

(2) When did it happen?

(3) Where did it happen?

(4) Who was involved?

(5) What caused the event?

(6) What steps, if any, should be taken to prevent a reoccurrence of this event?

c. Battalion QA/QI committee will investigate all MVRs and either formulate action or forward to the command and division QA/QI committee for further evaluation.

d. All MVRs will be forwarded to the force QA/QI committee chairman for review and signature.

8. Occurrence Screening

a. Occurrence screening is a QA/QI tool that focuses on the quality of care given to a patient as documented in their record. Occurrence screening is established to access appropriateness and completeness of care given.

(1) The following events will initiate an occurrence screen

(a) Morbidity or Mortality, when occurring under the cognizance of Navy medicine.

(b) Congressional Inquiry.

(c) Medication error/drug reaction.

(d) Significant trends noted in provider's performance profile.

(2) The following might initiate an occurrence screening

(a) Inappropriate medical record entries.

(b) Prolonged patient waiting time.

(c) Lack of reasonable follow-up and non-compliance of follow-up.

(d) Repeated visits for medication, especially without a medical officer's evaluation.

(e) Timeliness of x-ray and lab requests.

(f) Timeliness of return of consultation reports.

(g) Procedural errors in treatment.

(3) Occurrence screening MUST answer the following

(a) What happened?

(b) When did it happen?

(c) Where did it happen?

(d) Who was involved?

(e) Was adequate care rendered, and if not, where did it cease?

(f) What is the expected outcome?

(g) Will the patient have any debilitating residuals?

(h) What could have been done to achieve a better outcome?

(i) What steps, if any, should be taken to prevent a reoccurrence of this situation?

b. Battalion QA/QI committee will determine the categories of occurrences and will report any finding greater than Category II screenings to the force QA/QI committee.

c. All occurrence screen reports, regardless of category level will be forwarded to the division QA/QI committee chairman for signature.

d. Information concerning the numbers and types of occurrence screens will be included in the battalion QA/QI minutes of their meetings.

e. Occurrence screen reports are QA/QI documents and as such will NOT be duplicated nor retained at the unit level. After these documents are logged, they will be forwarded to the next higher level for action, then upon completion forwarded to the force QA/QI coordinator for filing.

9. Patient Satisfaction Survey Reports

a. Patient Satisfaction Survey Reports will be completed by the unit Patient Contact Representative (PCR).

b. The collection of patient satisfaction data is the responsibility of the unit PCR.

c. Patients will be afforded the opportunity to comment on their treatment in all force medical units. This survey will be made available to all patients when the medical unit is in operation.

d. All patient complaints, whether received verbally or as part of the collection of patient satisfaction surveys will be referred to the unit PCR for validation. Validated complaints, as well as compliments received will be part of the clinic performance profile monthly report.

10. III MEF Patient Contact Representative Program

a. The III MEF Patient Contact Representative Program is an integral part of providing total quality medical care.

b. The PCR will be the SMDR within each division unit.

c. Each patient contact will be reported utilizing the contact information sheet.

d. Each PCR will be a member of the unit's QA/QI committee, and will report contacts and findings at the QA/QI committee meeting.

e. The III MEF Patient Contact Representative Program Manager will be a senior enlisted member appointed by the Force Surgeon and be a member of the force QA/QI committee. Patient Satisfaction

Survey Report for any unit will be submitted semi-annually to the force QA/QI committee.

11. Medical Officer Screening Health Records

a. All hospital corpsmen progress note entries in medical records shall be in standard "Subjective, Objective, Assessment, and Plan" (SOAP) format. The administrative portion of selected medical record entries shall be reviewed by the QA/QI coordinator. The medical content of all entries, involving standards of care, shall be reviewed and countersigned by a medical officer. His/her signature indicates that she/he approves of the care rendered and assumes full responsibility for that care.

b. The numbers of record entries reviewed shall be recorded along the numbers of entries which requires corrective action.

c. The medical officer shall determine which improper entries constitute significant deviations from standards of care. These occurrences will be entered into the provider's Clinical Performance Profile.

d. Significant deviations and occurrences will be reviewed by the regimental/battalion QA/QI committee with a summary sent to the division QA/QI committee.

e. A temporary record of all improper entries will be maintained by battalion QA/QI coordinators as a yardstick to measure trends in an individual provider's standard of performance. This will trigger corrective action and be utilized as a tool for improvement.

12. Annual Reports. Management information reports on QA/QI activities within III MEF are due to BUMED via U.S. Marine Corps Forces Pacific, in January of each year.

J. L. BRENNAN
Chief of Staff

Distribution: LIST I/II

Sample Appointment Letter for QA/QI Committee Member

Force Surgeon Letter Head

6320
ORIG
DATE

From: Force Surgeon, III Marine Expeditionary Force
To: Rank, Name, USN, SSN

Subj: APPOINTMENT AS III MEF QUALITY ASSESSMENT/QUALITY IMPROVEMENT (QA/QI) COMMITTEE MEMBER

Ref: (a) BUMEDINST 6010.13

1. In accordance with the reference, you are hereby appointed as a member of the III MEF Quality Assessement/Quality Improvement Committee.

2. You are directed to familiarize yourself with the reference and the III MEF program.

3. This appointment will terminate upon assignment to another position or transfer from this unit.

_____
Signature of Force Surgeon

ENCLOSURE (1)

Sample Appointment Letter for III MEF QA/QI Coordinator

Command Letter Head

6320
ORIG
DATE

From: Commanding General
To:

Subj: APPOINTMENT AS REGIMENTAL/BATTALION QUALITY ASSESSMENT/QUALITY IMPROVEMENT (QA/QI) COORDINATOR

Ref: (a) ForO 6320.3

1. In accordance with the reference, you are hereby assigned to the position of Battalion Quality Assessment and Quality Improvement Coordinator. You will carry out your duties as prescribed in the reference.

2. This assignment will terminate upon assignment to another position or transfer from this unit.

Force Surgeon By Direction

Copy to:
Force QA/QI Coordinator

ENCLOSURE (2)

Sample Appointment Letter for PEER Review

Command Letter Head

6320
ORIG
DATE

From: Force Surgeon, III Marine Expeditionary Force
To: Surgeon, Headquarters and Service Battalion, III Marine Expeditionary Force

Subj: ASSIGNMENT OF PEER REVIEW

Ref: (a) BUMEDINST 6320.66B

1. In accordance with the reference, you are hereby assigned as PEER Reviewer for Dr. Smith, 7th Communication Battalion, III Marine Expeditionary Force.

2. This assignment terminates upon your assignment to another position or upon your PCS from this unit.

M. HINKSON

ENCLOSURE (3)

SAMPLE FORMAT FOR QA/QI MINUTES

UNIT ADDRESS

1400
SURG
(Date)

From: Chairman, III MEF QA/QI Committee
To: Commanding General, III Marine Expeditionary Force
Via: Chief of Staff, III Marine Expeditionary Force

Subj: III MARINE EXPEDITIONARY FORCE QA/QI COMMITTEE MINUTES FOR THE MONTH OF _____
(month\year)

Encl: (1) Attendance Matrix
(2) Agenda
(3) Item Status Report

1. The Quality Assessment/Quality Improvement Meeting was held on 25 October 94 at 1430 at the Division Navy Personnel Office conference room. Enclosure (1) documents those in attendance. Enclosure (3) identifies the items for improvement.

2. Old Business. The Quality Assessment/Quality Improvement Minutes for the month of September were reviewed and approved by the Commanding General, 3d Marine Division.

(a) Item #940914.01: QA Plans

(1) Findings.

(2) Comments.

(3) Recommendations.

(4) Actions.

(5) Follow-up.

ENCLOSURE (4)

(b) Item #940914.02: Prescribing of Medications by Non-Physician

(1) Findings.

(2) Comments.

(3) Recommendations.

(4) Actions.

(5) Follow-up.

3. New Business

(a) Item #941025.01: Untimely return of Laboratory chits

(1) Findings.

(2) Comments.

(3) Recommendations.

(4) Actions.

(5) Follow-up.

4. With no further business for discussion, the meeting was closed at 1600. Next meeting will be held 29 Nov 1994 at 1400 in the Navy Personnel Office Conference Room.

M. HINKSON

ENCLOSURE (4)

ForO 6000.1
22 APR 1996

ATTENDANCE MATRIX
QUALITY ASSESSMENT
1996

NAME	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
CAPT HINKSON	A	A										
LT PETRILLO	A	A										
HMCS BALSLEY	A	T										
HMC HILVANO	E	A										
HMC EWALD	A	A										
HMC DECENA	A	A										
HM1 LUNA	A	A										
HM2 GRAY	A	A										
HM2 PEARSON	A	A										
HM2 MOSER	A	A										
HM3 LOOMIS	L	A										

A - ATTENDED
E - EXCUSED
L - LEAVE
T - TAD
U - UNEXCUSED/ABSENT
X - NO MEETING

ENCLOSURE (4)

ForO 6000.1
22 APR 1996

III MARINE EXPEDITIONARY FORCE
AGENDA FOR THE OCTOBER 1996 QUALITY ASSESSMENT MEETING

1. OPENING REMARKS

2. OLD BUSINESS

(a) CREDENTIALING ORDER FOR III MEF
(b) III MEF PHYSICIANS CREDENTIALED BY III MEF
(c) ICF RECORD REVIEW

3. NEW BUSINESS

(a) III MARINE EXPEDITIONARY FORCE PHYSICIAN'S RECORD REVIEW

4. CLOSING REMARKS

ENCLOSURE (4)

QUALITY ASSESSMENT
ITEM STATUS REPORT

MONTH/YEAR

PROBLEM #	PROBLEM DESCRIPTION	RESPONSIBLE PARTY	ACTION	REVIEW DATE	STATUS
OLD BUSINESS 940914.01	CREDENTIALING ORDER FOR III MEF	PROFESSIONAL AFFAIRS COORDINATOR	THE ORDER IS FINISHED AND READY TO BE FORWARDED UP THE CHAIN	NEXT COMMITTEE MTG	ONGOING
940914.02	III MEF PHYSICIANS BEING CREDENTIALED BY III MEF CG	CREDENTIALS COORDINATOR	CONTINUE CURRENT PRIVILEGING, CONTACT BUMED-35 FOR CORRECT PROCEDURE	NEXT COMMITTEE MTG	ONGOING
940914.03	ICF RECORD REVIEW	PROFESSIONAL AFFAIRS COORDINATOR	NOTIFY PHYSICIANS TO OBTAIN PHOTOS AND OF UPCOMING EXPIRATION OF TRAINING	NEXT COMMITTEE MTG	ONGOING
NEW BUSINESS 941025.01	ICF RECORD REVIEW OF III MEF PHYSICIANS	PROFESSIONAL AFFAIRS COORDINATOR	REQUEST EXITING PARs ON ALL PHYSICIANS AND COPIES OF ACLS, BLS AND ATLS CERTIFICATIONS	NEXT COMMITTEE MTG	ONGOING

ENCLOSURE (4)

ForO 6000.1
22 APR 1996

III Marine Expeditionary Force

Clinical Indicators/Aspects of Care

IMPORTANT ASPECT OF CARE:			RATIONALE:		
CLINICAL INDICATOR	% THRESHOLD	% COMPLIANCE			FINDING/DATA
	95%	NOV	DEC	JAN	
1. #PPDs Read in 72 Hours					
2. Total PPDs Given					
CONCLUSIONS: (Evaluate care or process based on evaluation of findings)					
RECOMMENDATIONS:					
ACTIONS TAKEN TO IMPROVE CARE: (Policy change, classes, educational link, data collection refinement, communication between Aid Stations)					
IMPROVEMENTS:					
FOLLOW-UP: (How the progress of this indicator will be tracked)					
SURGEON'S COMMENTS:					

ENCLOSURE (5)

ForO 6000.1
22 APR 1996

III Marine Expeditionary Force

Volume Indicators Tracking Sheet for FY**

Volume Indicators	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Outpatient Visits												
Rx Refills												
Immunizations												
Minor Surgery Cases												
Physical Exams												
PAP Smears												
Sickcall Patients												
Findings:			Recommendations:				Action:			Follow-up:		

ENCLOSURE (6)

ForO 6000.1
22 APR 1996

OUTPATIENT MEDICAL RECORD REVIEW

III Marine Expeditionary Force

Provider _____ Reviewer _____

Name of Patient _____ Date of Review _____

SSN of Patient _____ Date of Entry _____

To be completed by designated Corpsman	Threshold	Yes	No	N/A
1. Complete patient indentification box	100%			
2. Full 11 digit SSN	100%			
3. Phone numbers	100%			
4. Notation where record is maintained	100%			
5. Vital signs	100%			
6. Provider's Name, SSN and signature	100%			
7. Chronic conditions reported on problem summary list	100%			
8. Allergy history on problem summary list	100%			
9. Allergies and medications listed	100%			
To be Completed by Medical Officer	Threshold	Yes	No	N/A
10. History adequate	100%			
11. Physical exam appropriate	100%			
12. Lab and x-ray studies, Initialled, dated, acted upon by M.O.	100%			
13. Appropriate assessment	100%			
14. Appropriate treatment	100%			
15. Appropriate consultation	100%			

Comments (Required for negative responses)

ENCLOSURE (7)

ForO 6000.1
22 APR 1996

ISSUE REFERRAL REPORT

Date of Referral: _____

FROM:
TO:

1. Issue:

2. Please return a copy of this form to:_____

Item Status Number _____ has been assigned to this issue.

Signature

ACKNOWLEDGEMENT OF REFERRAL

Date:

FROM:
TO:

RESPONSE

1. Actions considered or taken:

2. Recommendation for continuous monitoring:

Signature

Copy to:
Referring Aid Staion
Force QI Coordintor

ENCLOSURE (8)

ForO 6000.1
22 APR 1996

Patient Satisfaction Survey

(Unit)

1. Approximately how many times have you been to the RAS/BAS in the last six months? _____

2. How long did you wait to be seen at the RAS/BAS? _____
   Was this longer than anticipated? YES ☐ NO ☐

3. If there were delays did the staff explain the reason for the delays.
   YES ☐ NO ☐

4. Do you feel that sufficient care was provided? YES ☐ NO ☐

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
5. Corpsmen: Were the Corpsmen courteous and helpful?	5	4	3	2	1
Did the Corpsmen answer your questions and keep you informed?	5	4	3	2	1
Did the Corpsmen take care of your needs quickly?	5	4	3	2	1
6. Doctor: Was the Doctor courteous and helpful?	5	4	3	2	1
Did the Doctor answer your questions and keep you informed?	5	4	3	2	1
Did the Doctor explain all tests or treatment?	5	4	3	2	1
7. Overall skill and professionalism of the staff that cared for you?	5	4	3	2	1
8. Aid Station: Cleanliness and comfort of the Aid Station?	5	4	3	2	1
Did the Staff explain to you what to expect and how to care for yourself after discharge? Corpsman:	5	4	3	2	1
Doctor:	5	4	3	2	1

ENCLOSURE (9)

Did you understand your treatment? YES ☐ NO ☐

9. What suggestions do you have for improving the Aid Station:

_____

_____

_____

_____

10. Any comments, complaints, or suggestions are appreciated.

_____

_____

_____

_____

UNIT (REQUIRED)	DATE (REQUIRED)	PRINTED NAME & RANK (OPTIONAL)	SIGNATURE (OPTIONAL)

Clinical Performance Profile

Practitioner Name: _____ SSN: _____

From: _____ (mm/yy) to _____ (mm/yy) 4 month period

	1st month	2nd month	3rd month	4th month
1. Volume Data				
a. Number of outpatient encounters				
b. Number of surgical cases				
c. Number of surgical cases deficiencies				
d. Number of days deployed and temporary additional duty (TAD) not available				
e. Percent of time in direct patient care				
2. Occurrence Screens				
a. Validated				
(1) Number of Category I				
(2) Number of Category II				
(3) Number of Category III				
(4) Number of Category IV				
3. Medical Record Review				
a. Number of records reviewed				
b. Number of administrative deficiencies				
c. Trend of administrative deficiencies:				

ENCLOSURE (10)

(1) Improving: _____/_____/_____/_____

(2) Worsening: _____/_____/_____/_____

(3) No Change: _____/_____/_____/_____

d. Number of Peer Review Standards of care variations _____/_____/_____/_____

e. Trend of standard of care variations:

(1) Improving: _____/_____/_____/_____

(2) Worsening: _____/_____/_____/_____

(3) No Change: _____/_____/_____/_____

4. **Infection Control**. Number of validated surgical wound infections _____/_____/_____/_____

5. **Drug Usage Review**

a. Number of validated deficiencies _____/_____/_____/_____

b. Number reviewed _____/_____/_____/_____

6. **Patient Contact Point Program**

a. Number of validated Patient compliments _____/_____/_____/____

7. **Liability Claims/JAGMAN Investigations/PCE Reviews in which Practitioner was Principal Focus**.

_____/_____/_____/_____

8. **Professional Development**

a. Number of continuing education credit hours awarded _____/_____/_____/_____

b. Other recognition of positive professional achievement* _____/_____/_____/_____

(Department Head) Initials * _____/_____/_____/_____

Practitioners Initials * _____/_____/_____/_____

* Attach Comments as Required

ENCLOSURE (10)